Wisconsin Department of Safety and Professional Services

Mail To: **P.O. Box 7190**
Madison, WI 53707-7190

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 266-2264
Phone #: **(608) 266-2112**

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MONITORING

TREATMENT REPORT FORM

If you have any questions regarding this report, please contact the Monitor at 608-267-3817.
Please provide as much detail as possible (use back of page or additional sheets, if necessary).

This form is to be completed by the Treater, not the client.

Patient/Client's name: _____

Treatment Focus: _____

How long have you been treating this client? _____
Does treatment consist of individual sessions? _____
Does treatment consist of group sessions? _____
Type of Group: _____ Facilitator: _____

Dates of sessions in the last 3 months:

_____
_____

Please discuss client's progress in treatment over the past 3 months:

_____
_____
_____

Please discuss treatment plans for the next 3 months:

_____
_____
_____

Are you recommending any modifications to the Order? ( ) Yes ( ) No If yes, please specify:

_____
_____
_____

Do you feel this client is able to competently practice in his/her professions? ( ) Yes ( ) No
If no, please explain:

_____
_____
_____

Prognosis?

_____
_____
_____

Please describe difficulties encountered in providing services for this client:

_____
_____
_____

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If client is recovering from an addiction, please answer these additional questions:

What addiction(s) is he or she recovering from? Please be specific: _____

_____

_____

Please discuss acceptance of addictive disease and his/her willingness to acknowledge and accept the consequences of the disease:

_____

_____

_____

Please discuss concerns you have regarding this client's recovery:

_____

_____

_____

To the best of your knowledge, is this client remaining abstinent? ( ) Yes ( ) No If No, please explain.

_____

_____

To the best of your knowledge, is this client having difficulty in remaining abstinent?

_____

_____

_____

Number of AA/NA or self help meetings recommended per week? _____

Is this client meeting your recommendation? ( ) Yes ( ) No

To the best of your knowledge, is this client in compliance with his/her Board's order? ( ) Yes ( ) No

If no, please explain: _____

Please attach any drug screen results that you may have for this client.

_____ _____

Signature of Treater Date

_____ _____

Print name of Treater and Credentials Treater's License Number

_____

Name and address of treatment facility

(____)_____

Phone number

Please feel free to attach any additional information you wish to bring to the Monitor's attention.

Please mail, fax, or email this form every three months to:

ATTN: Department Monitor
Wisconsin Department of Safety and Professional Services
PO Box 7190
Madison, WI 53707-7190
Fax (608) 266-2264
dspsmonitoring@wi.gov